MONTANA MEDICAID CLAIM JUMPER

Volume XIV The Montana Medicaid Newsletter Summer 2001

DPHHS ANNOUNCES NEW MEDICAID COVERAGE

Effective July 1, 2001, Montana law provides for a new Medicaid eligibility group that will receive Basic Medicaid benefits through the Montana Breast and Cervical Cancer Treatment Program (MBCCTP). This Medicaid benefit will provide the flexibility to ensure that women who are screened through the Montana Breast and Cervical Health Program (MBCHP) and diagnosed with breast and/or cervical cancer or a pre-cancerous condition will get the help they need to pay for treatment.

Following are the eligibility criteria for coverage through MBCCTP:

- Must be screened through MBCHP and have a diagnosis of breast and/or cervical cancer or pre-cancer.
- Income level is 200% of federal poverty level or less.
- Patient may not have creditable insurance or other coverage to pay for treatment.
- Patient must be less than 65 years of age.
- Coverage will end when the patient has completed the cancer treatment determined by the physician or turns 65 years of age.

Medicaid coverage through the Montana Breast and Cervical Cancer Treatment Program is limited to Basic coverage. Services covered through Basic Medicaid include physicians, mid-level practitioners, hospital, and pharmacy.

Women covered through this new program must participate in the PASSPORT to Health Program and have a primary care provider to access most services. Primary care providers must make referrals to specialists.

For information regarding screening through the Montana Breast and Cervical Health Program, please call 1-888-803-9343.

Fee Schedules Available from Provider Relations

Fee schedules for most types of providers are updated twice a year, usually in January and July, and are available upon request. You may either call, fax, or mail your request to Provider Relations. As with all written correspondence sent to Provider Relations, please make sure to include your provider number on your fee schedule request so we will be able to send you the fee schedule for your provider type. Fee schedules are also available at the DPHHS web site at www.dphhs.state.mt.us.

Provider Seminar Info En-

Billing Changes Coming for Rural Health Clinics and Federally Qualified Health Centers

On September 24, 2001, DPHHS will change the payment methodology for RHCs and FQHCs to a Prospective Payment System (PPS). PPS will use one all-inclusive payment rate per patient visit. Other ambulatory services will be included in this rate and will no longer be separately billable. Clinics will be limited to revenue codes 521 for RHC clinic visit, 529 for FQHC clinic visit, 522 for visiting nurse (you must be in a shortage area to use this) and 512 for clinic dental visit. Through PPS, clinics will receive the same rate per visit regardless of the procedure or diagnosis code. Clinics will be limited to one visit per day, with the exception of a separate mental health and/or dental visit. New provider manuals for RHCs and FQHCs will be mailed out in mid-September. Training for billing under PPS will be available at the Fall Provider Training Seminars (see insert for more information on this training opportunity).

THIRD PARTY LIABILITY CLAIMS

The Third Party Liability (TPL) Unit at ACS is available to assist providers with problems relating to other insurance coverage. Examples of claims to send to the TPL Unit include:

- If you submitted a claim to another insurer and haven't had a response within 90 days, send the claim to TPL with documentation attached that another insurer was billed and when. The TPL Unit can then have your claim processed for Medicaid and will follow up with the other insurer for payment.
- If you have information that a Medicaid client is no longer covered on the insurance plan listed on their Medicaid card, please send your claim along with documentation of proof of termination of coverage from the insurance company to the TPL Unit. The TPL Unit will have your claim processed and will verify that coverage has ended with the insurance company. The TPL Unit can then have the insurance removed from future Medicaid cards for that client.

Please include a note with any problem claim sent to the TPL Unit indicating the situation and what you would like to be done to resolve the problem. Claims received by TPL without a note attached will be sent through for normal processing and will not receive any special attention.

The following are examples of claims involving other insurance that need not be sent to the TPL Unit. They should be submitted to ACS, PO Box 8000, Helena, MT 59604, for normal processing:

- If an insurance company paid on a claim you will be submitting to Medicaid, you need only indicate the amount the insurance paid in the appropriate field of your claim form.
- If the insurance company denied or if the allowed amount went towards the patient's deductible, you must attach a copy of the insurance EOB to the claim. Make sure that the EOB includes the statement indicating why the claim denied.
- Medicare cross-over claims.

First Montana Medicaid Provider Fair a Success

Thanks to the participation of over 200 providers and to the efforts of the many people involved in planning and production, the first Montana Medicaid Provider Fair held on Friday, June 15, 2001, in Helena was a resounding success! The break-out session format was very popular among attendees. With providers attending from throughout Montana and bordering states, the Fair was a wonderful networking opportunity.

We are already in the planning stages for the 2002 Montana Medicaid Provider Fair. Please be on the look-out for more information in upcoming issues of the *Montana Medicaid Claim Jumper.*

Recently Released Publications

The following is a list of publications sent out since the release of the last *Claim Jumper*. If you would like extra copies of these publications, please contact ACS Provider Relations.

Date	Sent to	Topic
4/17/2001	Ambulance Providers	New procedure codes effective 4/1/2001
5/9/2001	Physicians, Mid-Level Practitioners, Public Health Clinics, Hospitals, FQHCs, & RHCs	Medicaid coverage of Mifepristone
5/9/2001	Pharmacies & Prescribers	Mandatory generics, DAW, & formulary changes
5/29/2001	Physicians, Psychiatrists, Podiatrists, Mid-Level Practitioners, Labs, Hospitals, Public Health Clinics, FQHCs, & RHCs	Billing for lab panels
5/30/2001	Blaine, Hill, Cascade, Fergus, Chouteau, & Phillips County Providers	Blaine County clients enrolled in PASSPORT to Health
6/1/2001	Dental Providers	Program changes effective 7/1/2001
6/1/2001	Physicians, Mid-Level Practitioners, EPSDT Providers, Podiatrists, Dentists, Optometrists, Public Health Clinics, Audiologists, & Psychiatrists	Global surgery period billing requirements
6/8/2001	All Enrolled Providers	Eligibility denials & third party liability for communal living
6/19/2001	Private Duty Nursing Providers	Prior authorization time periods
6/27/2001	Ambulance Providers	Procedure codes & payment changes effective 7/1/2001
7/2001	Pharmacy Providers	Pharmacy provider manual
7/2001	Dental and Denturist Providers	Dental/Denturist provider manual
7/2001	Audiology Providers	Audiology provider manual
7/2001	Hearing Aid Providers	Hearing Aid provider manual
7/2001	Optometric Providers	Optometric provider manual
7/2001	Eyeglass & Optometric Providers	Eyeglass services provider manual
7/2001	Durable Medical Equipment Providers	Durable Medical Equipment provider manual
7/2001	Hospital Providers	Inpatient hospital services provider manual
7/3/2001	Private Duty Nursing, Personal Assistance, Home & Community Based Services, Physicians, & Mid-Level Practitioners	Nutrition administration changes
8/15/2001	Hospital Providers	HCPCS coding clarification

INFORMATION TELEPHONE NUMBERS

Provider Relations	1-800-624-3958 (Montana Providers) (406) 442-1837 (Helena and Out-of-State Providers) (406) 442-4402 (FAX)		
FAXBACK	1-800-714-0075	AUTOMATED VOICE RESPONSE	1-800-714-0060
Point-of-Sale Help Desk	1-800-365-4944	PASSPORT	1-800-480-6823
Direct Deposit	(406) 444-5283		

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Top Denial Reasons for UB-92 Outpatient Claims Submitted on Paper and How to Avoid Them

The most common denial reason for UB-92 outpatient claims is that a claim for the exact same service (s) was previously submitted and paid. Timely working of your Remittance Advice and posting to your accounts receivable is the best way to prevent unnecessary resubmission and denial.

The second most common denial reason is that a Medicaid client has a primary payer other than Medicaid on file but the provider's claim to Medicaid neither shows another insurer's payment nor includes another insurer's EOB. When you verify a client's Medicaid eligibility, you also will receive any information we have on file about other insurance coverage.

Verification of Medicaid eligibility is key to preventing the next most common denial reasons which are that the client is not eligible on the date(s) of service or the client's ID number is not on our file. The best way to verify eligibility is to require that clients present their Medicaid ID cards for every visit. We realize this is not always possible. In those cases where you cannot view a Medicaid ID card, we recommend you verify eligibility by using one of the following methods: Automated Voice Response, FAXBACK, or the Medicaid Eligibility and Payment web site.